

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Revised PO

PRINTED: 02/04/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2010
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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MCMINNVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252 SS=D	<p>483.15(h)(1) ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide an odor-free environment for two residents (#8, #17) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on August 12, 2002, with diagnoses including Schizophrenia, Irritable Bowel Syndrome, and Cerebrovascular Accident. Review of the Minimum Data Set (MDS) assessment dated December 3, 2009, revealed the resident had bowel and bladder incontinence daily, and required extensive assistance with personal hygiene and bathing. Review of the nurse's note dated January 5, 2010, revealed, "...Remains totally incontinent and urinates on each turn also - Has a constant dribble and foul smell to urine. Often with loose stools ..." Review of the nurse's note dated January 13, 2010, revealed, "...Foul odor to urine ..."</p> <p>Resident #17 was admitted to the facility on August 29, 2008, with diagnoses including Congestive Heart Failure, Osteoporosis, Hypertension, and Coronary Artery Disease. Medical record review of the Minimum Data Set (MDS) assessment dated December 1, 2009, revealed the resident required extensive</p>	F 252	<p>F252</p> <p>Patient #8 finished treatment for UTI on 12/29/2009. Placed on cranberry pills & is being followed by SilverCare Nurse Practitioner, who specializes in urinary issues. Patient #8 given new mattress on 1/26/2010 & room thoroughly cleaned. Room rounds were conducted on January 26, 27 & 28th by Department Managers (Bookkeeping, Social Work, Dietary, Housekeeping, Medical Records, Activities) to determine if other patient rooms had odor. None noted. Licensed nurses and C.N.A.'s in-serviced by Director of Nursing on appropriate incontinence care, completed on 2/4/2010. Director of Nurses will QA #8 & #17's patient room for odor, including patient interviews weekly times 4 weeks and monthly times 3 months until substantial compliance is achieved. Department Managers (Bookkeeping, Social Work, Dietary, Housekeeping, Medical Records, Activities) to conduct room rounds throughout the remaining rooms in the healthcare center weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. Results to be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p>Completion Date:</p>	2/4/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Administrator 2-12-2010

A deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

* Revised acceptable POC *

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MCMINNIVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 252	<p>Continued From page 1</p> <p>assistance for transfers, and was dependent on staff for personal hygiene and bathing. Continued review of the same MDS revealed the resident was incontinent of bowel and bladder daily.</p> <p>Observation during the initial facility tour on January 26, 2010, at 10:20 a.m., revealed resident #8 and #17 were roommates. Observation at this time revealed a strong, stale, pungent, urine odor present in the residents' room. Observation on January 26, 2010, at 1:30 p.m., and January 27, 2010, at 8:50 a.m., revealed the strong, stale, urine odor remained. Observation on January 27, 2010, at 8:50 a.m., revealed resident #17 and resident #8 had breakfast trays on their over-bed tables. Observation revealed resident #17 complained twice about the odor stating, "It is not very appetizing trying to eat when it smells so bad."</p> <p>Interview with Licensed Practical Nurse #1 on January 27, 2010 at 9:30 a.m., at the 200 hall nurses station, confirmed the room of resident #8 and #17 had a chronic foul odor; sometimes worse than others.</p> <p>Interview on January 27, 2010, at 4:45 p.m., in the hall, with a family member, confirmed, "...the room has had a foul odor for sometime ..."</p> <p>Continued interview confirmed the family member visited resident #17 on a weekly basis.</p>	F 252			
F 312 SS=D	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MC MINNVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 312	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide nail care for one (#6) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on September 22, 2005, with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Osteoarthritis. Medical record review of the Minimum Data Set dated November 7, 2009, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living including nail care.</p> <p>Observation on January 26, 2010, at 10:30 a.m., in the resident's room revealed the resident in bed receiving a bed bath from a Certified Nurse Assistant.</p> <p>Observation on January 27, 2010, at 9:15 a.m., and 1:00 p.m., in the resident's room revealed the resident in bed, eyes closed, and scratching the nose with the right index fingernail. Observation revealed the fingernail was jagged and soiled with dark debris under the fingernail tip. Observation revealed the remaining fingernails on the right hand also had dark debris under the finger nails; the left hand was under the covers.</p> <p>Observation on January 28, 2010, at 12:15 p.m., in the resident's room revealed the resident in bed feeding self with the right hand using the fingers and a fork; the five right hand finger nails</p>	F 312	<p>F312</p> <p>Patient #6's nails were cleaned and trimmed on 1/28/2010. All patient's nails were checked on 1/28/2010 by licensed nurses and C.N.A.'s under the direction of the Director of Nursing and proper nail-care was administered as needed. Licensed nursing staff and C.N.A.'s in-services were completed on 2/4/2010 by Director of Nursing regarding proper nail-care. Director of Nursing, Assistant Director of Nursing and C.N.A. Instructor to QA patient nail care weekly times 4 weeks and monthly times three months or until substantial compliance is achieved. Results to be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p>Completed date:</p>		2/4/2010

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F 312	Continued From page 3 were soiled with dark debris; and the index finger nail was jagged; the left hand middle and thumb nails were soiled with dark debris.	F 312			
F 315 SS=D	Interview on January 28, 2010, at 12:20 p.m., with Licensed Practical Nurse #2 in the resident's room confirmed the resident's finger nails were soiled with dark debris and required cleaning and trimming. 483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to provide incontinence care for one incontinent resident (#17) of seven incontinent residents reviewed. The findings included: Resident #17 was admitted to the facility on August 29, 2008, with diagnoses including Congestive Heart Failure, Osteoporosis, Hypertension, and Coronary Artery Disease. Medical record review of the Minimum Data Set (MDS) assessment dated December 1, 2009,	F 315	F315 Director of Nursing in-serviced C.N.A. #1 on 1/27/2010 on correct incontinence care per policy. Director of Nursing confirmed correct incontinence care on patient #17 by C.N.A. #1 after in-service on 1/27/2010. Director of Nursing interviewed C.N.A.'s on January 27 th & 28 th to determine knowledge of correct incontinence care techniques. Licensed nursing staff and C.N.A.'s education completed on 2/4/2010 by Director of Nursing on correct incontinence care techniques. Director of Nursing, Assistant Director of Nursing, and C.N.A. Instructor to Q.A. proper incontinence care techniques weekly times 4 weeks and monthly times 3 months until substantial compliance is achieved. Results to be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). Completion date:		2/4/2010

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F 315	<p>Continued From page 4</p> <p>revealed the resident had short term memory deficits with moderately impaired cognitive skills for daily decision making. Continued review revealed the resident required extensive assistance for transfers, was dependent on staff for personal hygiene and bathing and was incontinent of bowel and bladder.</p> <p>Observation on January 27, 2010, at 8:50 a.m., in the resident's room revealed Certified Nurse's Aide (CNA) #1 provided incontinence care to the resident after the resident had voided. Observation revealed CNA #1 positioned the resident on the left side, sprayed peri-wash on the resident's buttocks, and wiped the area with a dry towel. Observation revealed CNA #1 changed the incontinence pad, repositioned the resident in a supine position, and covered the resident with the sheet and blanket.</p> <p>Review of the facility policy, Perineal Care, revealed, "Purpose: Perineal cleansing will be done after incontinent episodes ..."</p> <p>Interview with CNA #1 on January 27, 2010, at 9:00 a.m., in the resident's bathroom, confirmed the resident had not been cleansed from the front and the incontinence care was incomplete.</p> <p>Interview with the Corporate Nurse in the Director of Nurses office on January 28, 2010, at 8:30 a.m., confirmed the facility policy for providing incontinence care had not been followed.</p>	F 315			